EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name	Grade
Address	Date of Birth
Bus number (if student is on a route)	Home Phone #

Student resides with: Both parents ☐ Mother ☐ Father ☐ Shared Parenting ☐ Grandparent ☐

Step father ☐ Step mother ☐ Other ☐ _____

Note: Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school. A non-custodial parent has the right to be listed as an emergency contact unless a court order or other legal document stating otherwise has been presented to the school.

Mother's Name	Address if different than student	
	City	State
Employer	Work Phone #	
Cell Phone #	Email address	

Father's Name	Address if different than student	
	City	State
Employer	Work Phone #	
Cell Phone #	Email address	

Does this student carry a cell phone?	**NO** ☐	**YES** ☐	Cell phone #

Reminder, cell phones should be off during school day.

Name of Relative/Child Care Provider Please provide AT LEAST 3 who could either:

1. Help contact a parent 2. Pick your child up in case of an emergency/illness

Name	Relationship
Address	Daytime phone #
City, State	Alternate phone #

Name	Relationship
Address	Daytime phone #
City, State	Alternate phone #

Name	Relationship
Address	Daytime phone #
City, State	Alternate phone #

CONSENT FOR EMERGENCY MEDICAL TREATMENT
PART I OR II *MUST* BE COMPLETED

PART I: TO GRANT CONSENT

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by doctors named on the reverse side of this form, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

X Date _____ **Signature of Parent/Guardian** _____

PART II REFUSAL TO CONSENT:

If you refuse consent for EMERGENCY MEDICAL TREATMENT of your child, please attach a signed letter stating what action you wish school authorities to take in case of an emergency for your child

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

Coldwater Schools 20__-20__

STUDENT NAME

The information given below is shared with teachers and support staff when appropriate. It is also used to alert hospital personnel of your child's history in case of an emergency where the parent cannot be reached:

I give consent for the information below to be shared with the staff as needed for my child's safety and well-being.	NO ☐	YES ☐
1. Does your child have Diabetes? * Insulin dependent ☐ Non insulin dep. ☐	NO ☐	YES ☐
2. Does your child have Asthma? *	NO ☐	YES ☐
Will your child need asthma medication at school or school events** (sports, band, etc)?	NO ☐	YES ☐
IF YES (even if your child will just sometimes will need it) Inhaler ☐ Nebulizer ☐		
** *Remember to have a new prescription medication permission form on file each year for child to have medication at school.*		
What medication?* ☐ keep in building office ☐ student keeps		
Where will student keep it? ☐ Pocket ☐ Locker ☐ Book / Sports bag Other		
IF NO: ☐ My child takes medication at home to control Asthma symptoms (list below in question 8)		
OR ☐ My child does not require any medication to control asthma symptoms most of the time.		
3. Does your child have or has your child had a seizure disorder?*	NO ☐	YES ☐
Last Seizure? Medication for seizures		
Type of seizures (describe seizure)		
4. Does your child have any food allergies?*	NO ☐	YES ☐
IF YES: Food allergy Reaction		
5. Does your child have a ***serious*** allergic reaction to bee stings?*	NO ☐	YES ☐
Will your child need medication** to treat bee/wasp stings at school or school events?	NO ☐	YES ☐
What Medication? (All medication is provided by parent.) ☐ Antihistamine ☐ Epipen Other		
***Remember to have a new medication permission form on file each year for child to have medication at school.*		
Describe typical reaction: (check) ☐ Trouble Breathing ☐ Major Swelling over body ☐ Hives		
☐ Major Swelling at site of sting ☐ Minor swelling Other		
6. Is your child **ALLERGIC** to any medication? Please Specify:	NO ☐	YES ☐
7. Does you child have any environmental allergies? Please Specify:	NO ☐	YES ☐
8. Is your child **ON** any medication?	NO ☐	YES ☐
Name of Medication:		
9. Does your child have any other medical condition or anything else you want the school to know about?	NO ☐	YES ☐
If yes, please specify:		
10. Does your child have any limitations in regards to participating in any school activity?	NO ☐	YES ☐
Please list limitations		

**If yes, you may be sent a more specific form to fill out concerning your child's condition.*

Physician		City, State		Phone
Dentist		City, State		Phone
Eye Doctor		City, State		Phone
Medical Specialist		City, State		Phone

Note: In an emergency 9-1-1 will be called and your child will be transported to the nearest appropriate medical facility. In case of serious injury or illness, we will attempt to notify a parent. If a parent cannot be contacted, then all Emergency Medical Release directives apply. This form or a copy of this form will be sent with the student to the emergency facility.

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

OFFICE USE ONLY	Reviewed by	Date